The legality of Article 13 of the proposed revised Dutch healthcare law

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Advice: Article 13 of the proposed Dutch health insurance law: compatibility with European Union law

A. THE REVISED DUTCH HEALTH CARE SYSTEM AND ARTICLE 13

1. Article 13 of the proposed new Dutch health insurance law (Zorgverzekeringswet) provides that if patients go to a health care provider who does not have a contract with their insurer then the insurer is not obliged to reimburse their costs. This article is in the context of a revision of the Dutch health care system. It is envisaged that in the future insurers will select a limited number of health care providers and make large-scale contracts with these. Clients of those insurers who have what is called a 'natura' policy (a benefits-in-kind policy) will then only be entitled to care from those contracted providers. Insurers would rather deal with a smaller number of providers, which each treat a larger number of patients.

2. In practice, there will be few if any contracts with foreign health care providers, as the number of patients who wish to go abroad for treatment is generally low by comparison with those who wish to be treated in their own state. Foreign clinics may be attractive for some but will in general not be logical places to conclude bulk contracts with.

3. Patients who wish to have greater freedom to choose their own healthcare may opt for a different kind of policy, a so-called restitution policy. This allows them to go to the provider of their choice and be reimbursed. It is however envisaged that only a small proportion of patients will choose for a restitution policy, as it will be more expensive.

4. Patients with a benefits-in-kind policy, the majority of the Dutch population, will then not be able to go to foreign healthcare providers, except where there is a contract with that provider (which may occur for certain kinds of treatment, or in certain border areas, but will be the exception). If they do go to a foreign provider with whom there

is no pre-arranged contract, the insurer is entitled, under Article 13, to refuse reimbursement.

The question arises whether this arrangement is compatible with European Union law.[1]

B. COMPATIBILITY WITH DIRECTIVE 2011/24 ON FREE MOVEMENT OF PATIENTS

1. Article 7(1) of the directive provides that

> Without prejudice to Regulation (EC) No 883/2004 and subject to the provisions of Articles 8 and 9, the Member State of affiliation shall ensure the costs incurred by an insured person who receives cross-border healthcare are reimbursed, if the healthcare in question is among the benefits to which the insured person is entitled in the Member State of affiliation.

2. The Dutch minister responsible for health has expressed the view that this provision is more generous to states than the previous case law of the European Court of Justice.[2] She has suggested that if only contracted healthcare is reimbursed within the Netherlands then Article 7(1) merely imposes an obligation to reimburse contracted healthcare outside the Netherlands. So if a patient goes to a non-contracted foreign healthcare provider they have no right to reimbursement because 'non-contracted healthcare' is not one of the benefits to which they are entitled.[3]

This view is however completely without any basis in the law and appears to be based on a number of misunderstandings.

The Directive codifies the case law

3. The directive is not intended to change or restrict the case law of the Court. Rather it is intended to codify and clarify it. It is, as is very common in EU law, an exercise in translating judgments into clear written law. This is apparent from the directive itself. Recital 8 provides

> …This Directive is intended to achieve a more general, and also effective, application of principles developed by the Court of Justice on a case-by-case basis.

[1] This has also been considered by Prof. J.W. van de Gronden, in 'Grensoverschrijdend patiëntenverkeer in de Zorgverzekeringswet: is de voorgenomen wijziging van artikel 13 Europeesrechtelijk houdbaar?' Tijdschrift voor Gezondheidsrecht 2013 (37) 1. I am in agreement with his conclusions that the proposed change is unlawful. See paragraphs 30-41 of section B.

[2] See the letter to the 'Tweede Kamer' of 26th March 2012, reference Z-3109656, subject 'aanpassing artikel 13 van de Zvw'; Kamerstukken II 2011/12, 33 362, nr. 3, p. 36.

[3] Ibid.

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That suggests that the directive aims, if anything, to make the rights developed by the Court *more* effective, rather than to extend the circumstances in which a state may restrict them.

Recital 10 provides

> This Directive aims….to ensure patient mobility in accordance with the principles established by the Court of Justice…

There are numerous other provisions of the preamble which refer to the case law of the Court and make clear that the Directive is intended to implement this case law into legislation (paragraphs 11, 12, 26, 27, 38, 40, 43, 44).

It is therefore not surprising that the Commission understands the directive to be a *codification and clarification* of the case law. This is apparent from its presentations of patient rights to the public on the Commission website,[4] but is perhaps most directly put in its interpretative note on the directive and related legislation:[5]

> The Directive codifies a number of rulings of the Court of Justice of the European Union regarding the freedom of patients to seek medical services abroad and to be reimbursed for such services by their home Member State, and introduces a number of measures to facilitate the implementation of these rulings in practice.

Indeed, this is the universal academic understanding of the Directive, as numerous publications attest,[6] and one may expect it to be the understanding of the Member States given the preamble and the fact that the guidance note above was supplied to all those states.

The starting point for reading this Directive is therefore that it codifies the case law, and enhances the effectiveness of the rights granted in that case law. Any suggestion that it is an attempt to restrict the case law of the Court is without basis in the text, and appears to be shared by no-one.

Legal basis

4. It is further important to note that the Directive is adopted partly under the Article 114 competence for internal market harmonisation. That means that for it to be valid as legislation it must contribute to internal market goals, and in particular it must

[4] See e.g. European Commission - MEMO/13/918 22/10/2013, at http://europa.eu/rapid/press-release_MEMO-13-918_en.htm .
[5] Guidance note of the Commission services on the relationship between Regulations (EC) Nos 883/2004 and 987/2009 on the coordination of social security systems and Directive 2011/24/EU on the application of patients' rights in cross border healthcare, AC 246/12, 21st May 2012, at page 2.
[6] See the article by De La Rosa in the Common Market Law Review, the leading academic journal in this field, for discussion and many references: 'The directive on cross-border healthcare or the art of codifying complex case law' (2012) 49 CMLRev 15.

contribute to free movement.[7] Legislation which merely protects public health, or has other admirable goals, but does not in fact remove obstacles to free movement may not be adopted using Article 114.[8]

As a matter of law, therefore, the net outcome of this directive must be that patient mobility is *enhanced*. Where the Treaty grants free movement rights – as is the case for patients – a piece of secondary legislation which attempts to reduce those rights rather than to implement, enhance, or facilitate them would be invalid for lack of a legal base.

It is then perfectly predictable that the Directive preamble, and Article 1, emphasise that its function is to facilitate access to cross-border health care. The Commission's explanatory memorandum, attached to its initial proposal (and supplied to all Member States), explained in paragraph 4(a) (Legal Basis) that

> The Court's rulings on the individual cases outlined above are clear in themselves, and *no pre-condition may be required* [my italics] for the exercise of the rights of patients recognised by the Court. However, it is necessary to ensure a more general and effective application of these internal market rights in practice…..[9]

There is a recognition here that rights found by the Court cannot be taken away. The directive does not, and cannot, restrict rights which the Court has found to be inherent in the Treaty. It simply implements them into written law. It cannot be the case that patient mobility becomes harder as a result of the Directive's adoption.

The text of Article 7

5. Turning to the text of Article 7(1) itself it might be said to support two readings. The key phrase is 'the benefits to which the ensured person is entitled in the Member State of affiliation…' because these are the benefits to which they are entitled in other Member States too. The key question is then which are 'the benefits'. How should this phrase be read where a benefits-in-kind policy is involved? Are the benefits 'healthcare from contracted suppliers', as the minister would suggest? Or are the benefits 'healthcare of the sort within the Dutch 'basispakket' of insured treatments'? Does 'benefits' refer to the kind of medical treatment, or to the contractual status of the supplier of that treatment?

   On a natural reading of the text it is more natural to read benefits are referring to the sort of treatment, rather than its contractual context. That would suggest that, contrary to the minister's suggestion, the kinds of medical treatments for which the patient is

[7] Case C-376/98 *Germany v Parliament and Council (Tobacco Advertising)*
[8] Unless it is aimed at harmonising the conditions of competition, something not relevant to this directive.
[9] Proposal for a Directive of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare COM/2008/0414 final - COD 2008/0142

insured in the Netherlands must also be reimbursed if supplied abroad (subject to later provisions of the directive, on which more below). The contractual context of a medical treatment is not really part of the 'type of benefit' which health insurance covered.

Imagine a conversation between two Europeans, and the question to a Dutch citizen with a benefits-in-kind policy, 'which benefits are you entitled to under the insurance in your country?' Would the more appropriate answer be 'care from contracted suppliers' or 'all necessary hospital and non-hospital treatment as listed in the basis-pakket….'? Would a more normal answer be by reference to the contractual status of the supplier or to the kinds of medical processes which the Netherlands guarantees to its citizens?

6. While this textual argument supports a reading of Article 7(1) which is incompatible with the minister's view, reading legal texts out-of-context is always a weak basis for an opinion, and particularly where European Union law – which is notably policy-based – is concerned. Yet if we examine the context, the suggested reading of the text is confirmed.

7. Firstly, later provisions in Article 7 and 8 of the directive deal with procedural requirements and conditions for obtaining healthcare abroad, justified restrictions on patient's rights, and derogations from the general principle of Article 7(1). This makes it rather nonsensical to incorporate the contractual conditions of the benefits-in-kind policy into the definition of 'benefits'. Rather, the logic of the two articles appears to be that first we decide which kinds of treatments a Member State covers, then in principle a patient is entitled to receive those abroad, and then we move on to whether specific features of the national healthcare system justify a derogation.

8. Secondly, this reading is supported by the fact that it is the one which most facilitates patient mobility, which most effectively implements the rights recognised by the Court in its case law, and is indeed closest to that case law. Given the discussions above it is almost beyond doubt that the directive should be read in the way suggested here, and will be so read by the Court. If the fact that a Member State chooses for a benefits-in-kind scheme is sufficient to exclude a right to foreign treatment wherever the foreign supplier is not contracted within that scheme, then all the case law of the Court is undone and the directive is largely useless in Member States with benefits-in-kind schemes.

9. The final confirmation of how Article 7(1) should be read comes from the precise wording of Article 7(1) itself. The phrase involved is not new in the directive, but almost cut-and-pasted from existing legislation and close to phrases used in judgments of the Court. Regulation 1408/71, now regulation 883/2004, is the other major piece of Union legislation on healthcare abroad. It allows patients an alternative regime to the Directive and Treaty rights. Instead of being treated abroad and

receiving reimbursement, they can also, under certain circumstances of medical need, be treated abroad as if they were insured in that state, on the same terms as persons insured in that state. When do they have this right? If the treatment in question is 'among the benefits provided for by the legislation..' of the home Member State.[10]

Prior to the Court's case law on patient mobility many Member States only provided medical care within their home system. Foreign health care was, one might say, not among the benefits provided by their domestic legislation. Yet this argument was never put forward to undermine the regulation. The 'benefits' provided by their home Member State was not understood to mean the benefits provided by the suppliers from which they were entitled to treatment, but the kinds of treatment – by reference to the sort of medical processes, not their contractual context.

When a phrase is repeatedly used in different legislative acts, in the same field, it is likely that it will be given the same meaning. The established understanding of how home benefits are to be understood will also be that applied to Article 7(1).

10. It is also worth noting the finding of the Court in Müller-Fauré, one of the leading judgments on patient mobility, and the one in which the Court first explicitly considered the Dutch benefits-in-kind system.[11] In that case it stated, among other findings, that

> In any event, it should be borne in mind that it is for the Member States alone to determine the extent of the sickness cover available to insured persons, so that, when the insured go without prior authorisation to a Member State other than that in which their sickness fund is established to receive treatment there, they can claim reimbursement of the cost of the treatment given to them only within the limits of the cover provided by the sickness insurance scheme in the Member State of affiliation. (paragraph 98).

The minister would presumably be in agreement with this, since she would take the view that it only entitles patients to treatment abroad where the foreign supplier has a contract with their insurer. However, that is not at all how the Court meant the phrase. It went on to decide in substance that despite the features of the Netherlands' system, and the restriction of patients to contracted suppliers, there was an obligation to reimburse foreign care if that *type of medical treatment was among the medical processes guaranteed to Dutch insured persons.* Benefits are not defined by the contractual position of the supplier, but by their medical content. That is how the Court meant the phrase above, very close to Article 7(1), and it is how it will read Article 7(1). It is somewhat odd that Article 7(1) is argued to limit Müller-Fauré since

[10] See Article 20, regulation 883/2004.
[11] Case C-385/99 Müller-Fauré.

that is precisely the case which contradicts the minister's understanding of 'the benefits to which the insured person is entitled'.[12]

Recital 33

11. A final note should be added on recital 33, which provides that

> This Directive does not aim to create an entitlement to reimbursement of the costs of healthcare provided in another Member State, if such healthcare is not among the benefits provided for by the legislation of the Member State of affiliation of the insured person. Equally, this Directive should not prevent the Member States from extending their benefits-in-kind scheme to healthcare provided in another Member State. This Directive should recognise that Member States are free to organise their healthcare and social security systems in such a way as to determine entitlement for treatment at a regional or local level.

This rather unclear paragraph appears to preview Article 7(1) but then goes on to speak of the directive not preventing extensions of benefits-in-kind. That may appear to suggest that where a patient is covered by a benefits-in-kind scheme extension to foreign healthcare is at the discretion of the Member State.

Despite the ambiguities in the paragraph, it cannot be understood in the sense above. If that were a proper understanding of the directive it would be a largely useless piece of legislation in many Member States, and indeed give Member States the option to effectively opt-out of patient mobility by adopting benefits-in-kind schemes. The latter part of the recital is not echoed in the directive text itself, and given all the other arguments above this one slightly unclear sentence is not enough to support a narrow view of patient rights.

Rather, it appears more likely that the recital wishes to suggest that while patients have a right to reimbursement of foreign care, that should not be understood as meaning that states are precluded from having contractual relations with foreign suppliers and so bringing them within the national benefits-in-kind scheme. That is often convenient for patients, and the directive does not wish to discourage it. However, it has nothing to do with the right that a patient has when he does in fact go to a non-contracted foreign healthcare provider.

Conclusion on Article 7(1)

[12] It is also worth noting that the understanding of benefits proposed in this opinion is also the one used by the Netherlands' government in Müller-Fauré. In that case the Netherlands' government argued, unsuccessfully, that to allow such patients to be reimbursed would 'extend the conditions in which benefits are awarded' (paragraph 51). It did not argue that it would 'extend the type of benefits'. Rather it appeared to understand 'benefits' in the normal sense, as types of medical care, not by reference to the type of supplier.

12. The most plausible meaning of Article 7(1), given the text, its context in the directive, the purpose of the directive, and its stated relationship to the case law, and the relationship of Article 7(1) to similar phrases in other legislation and case law, is that it requires Member States to ensure that if a Dutch patient would be entitled to undergo a certain kind of medical treatment in the Netherlands, within their insurance, then they must receive reimbursement for the same or similar kind of medical treatment received abroad. This can be stated, for the reasons above, with a high degree of certainty.

13. It is worth perhaps noting that this is also the view which is being presented to the public by the European Commission,[13] and by the United Kingdom.[14] Along with the Netherlands, the UK has been the state most often in conflict with EU law in this field, and whose healthcare system faced the most fundamental shock as a result of patient mobility. Nevertheless, despite being a state usually quite prepared to take a strong stand on EU law if it feels it has a good case, the UK informs its own patients via the National Health Service website that the Directive allows them to receive non-hospital care abroad as long as the treatment is of a kind that the NHS provides in the UK, and to have it reimbursed. The legal position of the Netherlands regarding the Directive – or perhaps one should say the legal position of the minister – appears to be entirely unique.

Article 7(7)

14. The Directive, like the case law, does not contain any absolute obligations. There are a number of sub-provisions nuancing the basic right to treatment abroad, but the most relevant here is Article 7(7) which provides that the same 'conditions, criteria of eligibility and regulatory and administrative formalities' may be imposed on foreign healthcare as on domestic. The only limit to this is that any such condition or formality must not be

> …discriminatory or constitute an obstacle to the free movement of patients, services or goods, unless it is objectively justified by planning requirements relating to the object of ensuring sufficient and permanent access to a balanced range of high-quality treatments in the Member State concerned or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources.

15. It could be argued that the nature of the benefits-in-kind policy means that the requirement that a provider have a prior contract with an insurer is a condition of payment for that healthcare which may then be extended to foreign healthcare. The question is then whether such a condition, and Article 13 ZvW which permits it, is discriminatory and/or justified.

[13] See http://europa.eu/youreurope/citizens/health/planned-healthcare/expenses-reimbursements/index_en.htm
[14] See http://www.nhs.uk/NHSEngland/Healthcareabroad/plannedtreatment/Pages/Article56.aspx

16. It is arguably discriminatory, since in practice it has the effect of largely excluding foreign suppliers, and ensuring that most healthcare is provided domestically. However, it could also be argued that domestic non-contracted suppliers are just as harmed as foreign suppliers, so that discrimination is not a good description of the situation.

17. Discrimination in European Union law is a notoriously slippery subject, upon which the Court is far from consistent. Thus while it is quite plausible that Article 7(7) would regard Article 13 ZvW as discriminatory and unlawful, it is not certain.

    What is certain, however, is that Article 13, by allowing restrictive policies, does create an obstacle to movement. In practice, it will be harder for patients to go abroad than to receive treatment in the Netherlands. Nevertheless, it may be argued that Article 13 is part of a policy which aims to promote planning, control costs, and avoid wastage, and that these goals are sufficient to justify its consequences. If such an argument was successful it would make Article 13 lawful.

18. It is important here to disentangle the policy argument from the legal one. Whether or not the policy of the proposed health insurance law is good healthcare policy, and does in fact contribute to planning, cost control etc is undoubtedly something about which healthcare experts could argue at length. However, Article 7(7) cannot be read as simply deferring to national policy goals, for that would render it ineffective law. By contrast, the legal question is how it would be understood by the Court of Justice, as the body authorised to provide definitive interpretations of Union law.

19. Here we are helped considerably by the fact that precisely these questions have already arisen in a series of cases, several involving the Netherlands.[15] In these the Court has recognised that planning, cost control and prevention of wastage are legitimate goals, and can, to some extent, be used to justify restrictions on free movement. However, it has also found that there are limits to such justification. In particular, it has found that while restrictions on hospital (intra-mural) care may often be justified by these reasons, restrictions on non-hospital (extra-mural) care cannot be. Indeed, Müller-Fauré and Watts both concerned benefits-in-kind systems similar to the one proposed by the new health insurance law, in which out-of-system care was not covered. The policy arguments which the Dutch government might put forward in favour of Article 13, concerning planning, cost, and wastage, were put forward in those cases by the Dutch and British governments respectively, and accepted in respect of hospital care, and rejected in the case of non-hospital care.

20. Given that the Court has already addressed the question of which justifications can be accepted and to what extent in these (and other) cases, and given that the directive codifies the case law, I cannot think of any reason why Article 7(7) would now

[15] Case C-157/99 Smits and Peerbooms; Case C-385/99 Müller-Fauré; Case C-72/04 Watts.

suddenly be read in a new way, to allow extended justifications for restrictions on free movement. On the contrary, it seems very clear that, as Article 8 of the Directive provides, a somewhat restrictive regime for hospital care is permissible, but, as Article 7(1) suggests, for non-hospital care the presumption is of patient choice. Were new factors to arise in the future which change the cost and waste entailed in patient mobility, even for non-hospital care, that might perhaps change the position, although it should be noted that the Court is generally very reluctant to allow the scope of rights to be reduced once they have been established.

21. Prima facie, therefore, the policy justifications which might be put forward for Article 13 would be rejected, since they have already been put forward in other cases, and were rejected in those, and nothing has changed.

The existence of the restitution policy

22. The minister has expressed the view that the situation is importantly different from that in Müller-Fauré, because of the existence of the restitution policy.[16] The existence of both types of policy alongside each other means that patients do in fact have the option of insurance for foreign healthcare, but also have the option, if they wish, of saving money by opting for a more restrictive insurance package which limits them to certain providers. Her understanding of the situation is that rather than the Netherlands depriving individuals of their right to foreign healthcare, it simply offers them the option whether they wish to exercise that right in practice, or would rather save some money.

    This is a novel and interesting argument, which is nevertheless entirely wrong and without much chance of success.

23. Legally, it misses the point. It is more of a policy argument than a legal one. The Directive is quite clear that all patients have the right to reimbursement for foreign treatment, not just those who have made an earlier choice to opt for a certain kind of policy. In fact, the Directive phrases the situation in terms of the obligations of states and insurers, rather than the rights of patients. The obligation on the Netherlands is to ensure reimbursement in accordance with Article 7. There is nothing in the Directive which provides for some limitation of that obligation to certain groups of patients. Such a limitation would in substance be a derogation from the principle of free movement, and cannot be imposed unless there is a basis in the Directive or Treaty for it. There is not. The existence of the restitution policy is legally quite irrelevant to the rights of a patient with a benefits-in-kind policy, who continues to enjoy Treaty and Directive rights as expressed in those documents.

[16] Kamerstukken II 2013/14, 33 362, nr. 10, p. 27-28 en 32-33; Kamerstukken II 2013/14, 33 362, nr. 3, p. 36-37.

24. A practical reason why the minister's argument would not be accepted can further be found in the consequences that it would have. It is envisaged that most patients will have benefits-in-kind policies. In practice, her view would mean that most Dutch patients would not enjoy patient mobility to any serious extent. That would render the Directive pointless. European Union law is always interpreted in the light of its goals, and even where there some provision in the directive which provided a hint of support for the minister's view (which there is not), the teleological approach of the Court would prevent it taking such a restrictive approach.

25. It appears that what the minister imagines is some sort of waiver of rights. The implicit suggestion is that patients may choose to enjoy full mobility rights, but may also, in return for financial advantage (reduced premiums) give up those rights. Such issues come up regularly in employment law in some states, and for example in the UK the government has proposed allowing employees to give up certain employment protection rights in return for a lump-sum payment. Such rules are always controversial, because they undermine rights which are part of broader public policy – about creating a certain kind of society – and because there is always the doubt whether the party waiving their rights really appreciates the consequences at the time of consent, and whether that consent is 'genuine' enough. The party consenting to a waiver of rights is almost always the weaker in the negotiation, which is why waivers are often not allowed. In general, the more fundamental the right the less likely it is that contractual waivers will be allowed by law.

26. Waivers of free movement rights has not arisen to my knowledge in European Union law, but suggested waivers of other rights have come before the Court of Justice, including in cases in which the Netherlands was involved.[17] The waiver of certain employment rights in a directive (in return for financial advantage), the waiver of the right of illegal third-country immigrants not to be detained in prisons with ordinary prisons, and, most relevantly, the waiver of certain rights to medical care within regulation 1408/71 (in return for exemption from certain premiums) have all been considered. In each case it was argued that (i) the individual had consented to the waiver and (ii) it was in their own interests: migrant workers did not want to pay premiums for a right that they might not use, some illegal immigrants actually preferred to be detained in prisons because they had more contact with their compatriots there, and the employed persons received compensatory benefits so that their overall position was not worse.

27. Nevertheless, the waiver argument was rejected in each case. While the facts are all quite complex, the principles of the rejection are consistent in all the cases, and emerge quite clearly from the judgments:

[17] See Case 324/86 Tellerup v Daddy's Dance Hall; Case C-345/09 van Delft v College voor Zorgverzekeringen; Case C-160/96 Molenaar; Case C-474/13 Pham.

i. The European Union law in question was compulsory and did not allow for derogation. If rights and obligations are contained in European Union law it is not open to Member States to unilaterally conclude contracts with individuals which deprive them of those rights.

ii. The consent in question cannot be accepted as justification for a different view. At the time when an individual agrees to give up certain rights, or not to enforce certain EU law rights, they may not fully appreciate the consequences, and their decision may be taken under some form of pressure or duress.

iii. As a matter of principle, the concept of a waiver of rights assumes that only the interests of the parties are at stake. However, EU rights are a matter of public policy, and it is of concern to the EU as a whole that rights contained in its law are enforced throughout the EU and granted to all individuals.

28. These principles translate very well to the current situation.

i. The Directive imposes obligations, and Member States may therefore not conclude or authorise contracts with individuals which allow escape from those obligations.

ii. Once a year a patient is permitted to change insurer. When they do so in November or December they do not know what may happen to them in March or April, and what treatment they will need. The time at which a patient needs to take a decision about where they wish to receive treatment is when the treatment is necessary, not at some earlier point. Moreover, the reality is that for many people the difference in premium between restitution and benefits-in-kind policies will make it difficult for them not to choose the latter, particularly since insurers will no doubt tell them that they are excellently insured. Only later may they come to regret this.

iii. There is a public policy issue involved. It is not only the interests of patients and insurers at stake, but of foreign healthcare providers', and indeed of the EU as a whole. The policy of free movement of services, and of the directive, is to create a single market for services, including healthcare services, in which patients are free to move throughout the EU for healthcare, with the consequence of improvements in quality and availability of healthcare throughout the EU. Member States cannot take action that is without regard to this policy and the interests of foreign healthcare providers. To do so would be to fundamentally misunderstand the nature of the internal market, and indeed membership of the EU.

It may be noted that forms of this argument are often considered by academics to underly a great deal of free movement law. The conditions under which individuals may buy, sell and receive goods and services, including public services, are not, contrary to the occasional behaviour of Member States, a purely national matter. The Union interest in removing borders and creating a single market is always implicit in the law and should be integrated into national rules.

29. In conclusion, the suggestion of the minister that individual rights to enjoy free movement of services in the medical sphere may be 'bought off' by reduced premium does not fit the letter of the law, nor its broader policy. It is without any serious chance of success.

The publication by Van de Gronden

30. One of the first people to signal that there were legal problems with the proposed Article 13 was Johan van de Gronden, Professor of EU law at Radboud University Nijmegen. He argued in the Dutch Journal of Health Law that Article 13 represented an incorrect implementation of the Directive, for reasons compatible with, and often similar to, those outlined above in this opinion.[18] I agree in substance with his conclusions on the unlawfulness of Article 13.

    His publication is worth mentioning specifically for the following reasons: as one of the Netherland's leading experts in this field, and indeed someone who enjoys an international reputation in the field of EU health regulation, his publication was widely read and discussed, and was brought specifically to the attention of the minister soon after it was published in early 2013. Because of the seriousness of his arguments and the issues he raised, she chose to respond publicly to his claim that Article 13 was unlawful in a written answer to the Dutch Lower House.[19] In her answer she also notes that the European Commission had indicated that a benefits-in-kind policy which restricted access to foreign care, and made reimbursement conditional upon a prior contract between foreign provider and insurer, would be contrary to the Directive and Treaty.

    Nevertheless, the minister took the view that both Van de Gronden and the European Commission had misunderstood the law.

31. The minister's answer revolves around whether the directive requires non-contracted foreign care to be reimbursed
    a. as if it were non-contracted domestic care (i.e. not reimbursed), or
    b. whether it should be reimbursed as if it were contracted domestic care (i.e. according to a tariff based on the fees paid to contracted domestic suppliers).

    Van de Gronden had provided a detailed analysis of this question, showing how the Court responds to contract-based healthcare systems, and explaining why the second view, b, was correct. (This opinion above provides further reasons[20]). He had noted that the government took a different view, and had explained at some length why he disagreed.

[18] See note 1 above.
[19] Kamerstuk TK, 2012/13, 33 362, nr. 7, pp 76-78.
[20] See paragraphs 1-29 of this opinion.

32. If the minister had substantive reasons why his arguments were wrong, this would have been an appropriate moment to mention them. She did not however engage with his criticisms, but instead offered three 'reasons' for maintaining her view, all very unsatisfactory.

33. First, she just repeated her assertion that Article 7 allows view (a) above. She did not address any of the reasons provided by Van de Gronden why this assertion was wrong. This part of her answer offers no new content, and is essentially just an unreasoned confirmation of her position.

34. Secondly, she argued that recital number 4 of the Directive supported her view. This provides that the Directive … 'should not result in patients being encouraged to receive healthcare outside their Member State…' She claimed that if a non-contracted foreign provider received more reimbursement than a non-contracted domestic provider this would amount to such encouragement.

35. This is entirely incorrect. If the cost of foreign treatment is reimbursed as if it were domestic contracted treatment then the decision to go abroad or stay at home is financially neutral, which is not an encouragement to go abroad. Patients stand to make no profit at all by going abroad (which they never do, as reimbursement is never obliged to exceed actual costs), and would presumably do so only in the event that they had some medical or personal reason for wishing to. It is the benefits-in-kind policy which actively discourages foreign treatment, and the possibility for reimbursement which essentially takes national borders out of the equation, to an extent, so that decisions about medical treatment are made on substance, and the patient is not pushed in any particular direction or other. This is not encouragement to go abroad. The minister appears to misunderstand not just the EU law, but how the domestic law would work.

36. In any case, this issue is not what recital 4 is intended to address. There is a policy concern that the possibility of patient migration might lead Member States to stop investment in healthcare, on the basis that certain kinds of expensive facilities can always be accessed abroad. It is considered desirable that Member States maintain adequate domestic facilities, so that patients always have the possibility of receiving treatment at home, and are never pushed abroad. Recital 4 is about ensuring that good health care is, as far as possible, available locally, and free movement cannot be used to allow Member States to evade the obligation to ensure this. If insurers were to conclude bulk contract with foreign suppliers, for example, at the expense of domestic ones (because the foreign ones were cheaper, for example), so that Dutch patients with benefits-in-kind policies who lived in certain areas were told that they must go for certain operations to Germany or Belgium, this would be contrary to the intent of recital 4. The minister's invocation of it as a justification for the refusal to pay for foreign treatment is however without logic or legal basis.

37. The final 'argument' that the minister put forward was that the Directive aimed to give patients' clarity about reimbursement of foreign treatment, and the new policy was entirely consistent with this, as it was now quite clear that those with benefits-in-kind policies would not receive reimbursement for care from any non-contracted providers.

38. This argument of the minister is just an irrelevance; yes, the new Article 13 is certainly clear, but the fact that the Directive aims to achieve clarity does not mean that any law which is clear is therefore compatible with it. The Directive aims to achieve clarity, but it repeats in various places that the reason for this is because clarity about rights and obligations facilitates free movement.[21] A law which clearly makes cross-border care impossible for most Dutch patients is not using clarity in the way that the Directive envisages.

39. At the end of her answer, the minister then develops certain policy arguments about the new insurance law. These are not related to its legality.

40. The minister does not, therefore, provide any substantive response to Van de Gronden, offering two very very weak arguments (about clarity and recital 4) and then simply reiterating without reasons a standpoint which he had already discussed and dismissed at length. The conclusion must be that the government does not have any reasons to believe in the legality of Article 13 other than those weak reasons which have been put forward already, and had already been dismissed by Van de Gronden (and are further critiqued in this opinion). This will be very relevant in the event that Article 13 is in fact adopted and an action for compensation for breach of EU law is pursued against the Dutch state.

41. With respect to the opinion of the European Commission, the minister's response was that the Commission had not been aware that people could also choose for a restitution policy. Therefore their opinion was based on incomplete information. For the reasons given above in this opinion,[22] I see no reason to think that the Commission's response would have been any different had it been aware of this, nor that the existence of the restitution policy makes any difference.

C. COMPATIBILITY OF ARTICLE 13 WITH THE CASE LAW OF THE EUROPEAN COURT OF JUSTICE

1. As will have been apparent from the above, the Court has had several opportunities to consider benefits-in-kind healthcare schemes, in the Netherlands and other Member States, and patients who nevertheless wish to go abroad. Despite the fact that such migration fits very uncomfortably with the nature of the schemes – as it would fit

[21] See e.g. recitals 23 and 56.
[22] See paragraphs 22-29 of this section.

uncomfortably with the envisaged Dutch healthcare system – the Court has nevertheless found that Member States are obliged to reimburse foreign care. Article 13 is clearly incompatible with this case law, and this does not in fact appear to be disputed by the minister, so that this point will not be explored in more detail.[23]

2. Rather, the position of the minister appears to be that it is no longer necessary to consider the case law now that the directive has been adopted, as this is now the relevant legal framework and renders the case law obsolete.[24]

   That is a fundamental misunderstanding of European Union law. All the rights articulated in the case law of the Court continue to have full effect, and to be fully applicable, quite independently of the directive.

3. Where the Treaty creates directly effective rights – as is the case with patient mobility – the direct effect of those rights is not affected by the adoption of secondary legislation. If the legislation is comprehensive it may no longer be necessary to refer to the Treaty directly, as the lex specialis rule indicates that the first point of call should be the legislation, and this may solve all legal problems. However, if there are gaps or ambiguities, then the Treaty will continue to be relevant and applicable, either for guiding the interpretation of the legislation, or in providing rights which the legislation does not provide. It is very common that even after the adoption of secondary legislation, often based on case law, Treaty rights continue to be litigated and successfully relied upon. The citizenship directive,[25] and regulation 1408/71, now regulation 883/2004, provide examples of this.

4. Indeed, regulation 1408/71 was, until recently, the primary legislative framework for cross-border healthcare, governing when treatment abroad should be provided and reimbursed, and by whom. This did not stop the Court from developing an entirely independent and parallel regime of patients' rights on the basis of free movement of services, and it is now the case that the regulation, now replaced by regulation 883/2004, must be applied alongside the Treaty rights, with both often applicable in a given case, and the patient able to rely on the set of rights which is most advantageous for them.[26]

5. Although the Directive is now in force, the Treaty rights also continue to be, and if the Directive fails to provide a right in a circumstance where the Treaty does – according to the case law of the Court – then a patient is entirely free to rely on the Treaty directly to enforce that right.

[23] It is emphasized in the documents cited above in notes 2 and 16 above that the government takes the view that the directive has superceded the case law, and this is what makes the new Article 13 possible.
[24] Ibid.
[25] Directive 2004/38.
[26] See Case C-368/98 Vanbraekel.

6. Partly for this reason I think it unlikely that the Court will interpret the Directive to mean anything different from its case law. However, even if the Directive does turn out to be in some sense a more limited regime of rights, the more extensive rights found in the Treaty continue to exist and be applicable in national courts and legal systems.

   Thus even if – which is unlikely – Article 7(1) only provides rights to healthcare from contracted foreign suppliers, so that the Directive is in fact essentially a procedural document, concerning a limited range of healthcare but addressing the practicalities and formalities surrounding it, that would in no way mean that the broader right to non-hospital healthcare from a supplier of choice, as articulated in the case law, has ceased to exist.

7. If this seems surprising to a national lawyer or politician it may be a failure to appreciate the specific and narrow role of the EU legislature. It is not, unlike a national parliament, able to make policy and law pursuing all the goals and ambitions which may contribute to a 'good life'. Rather, it is confined to legislation which pursues the specifically articulated goals of the EU. It is essentially an implementor of the Treaty, whereas the meaning of the Treaty is the prerogative of the Court. As such, secondary legislation is hierarchically inferior to the Treaty, and takes place within its framework, and therefore within the interpretations of the Treaty which the Court provides. In the context of EU law the Court, interpreting the Treaty, provides the frame within which the legislature must operate, rather than the other way round. Hence the repeated references in legislation to the Court's case law and the ubiquitous insistence that it is merely being codified and clarified.

D. CONCLUSION

1. In Müller-Fauré, as in other cases, the Court stated that

   > First, achievement of the fundamental freedoms guaranteed by the Treaty inevitably requires Member States to make some adjustments to their national systems of social security. It does not follow that this would undermine their sovereign powers in this field.

   One may doubt the complete coherence of this statement. Nevertheless, it represents the law. Member States may choose how to construct healthcare systems, but are required to do so in a way respecting EU law, and that law may in fact impose real restrictions on them, forcing them to abandon plans which they might otherwise have pursued, and to adjust policies.

2. In the context of the internal market, and the free movement of services, Member States are legally required to ensure that their healthcare systems actually, as a matter of fact, make it possible for insured persons to go abroad for healthcare, albeit that where hospital care is concerned some limitations apply. This is not some exercise in

formal anti-discrimination, a policy that can be complied with by clever linguistics, but a substantive demand which will be, as is always the case, substantively tested by the Court. The real question is, in practice, can people in the Netherlands actually make use of the wide range of healthcare providers in the EU, or, in practice, do features of their system keep them at home?

3. It is quite clear what the answer to this question would be if Article 13 were to be adopted. For the reasons above in this opinion it is contrary to EU law.

- It fails to comply with the Directive, in particular Article 7(1);
- the possible justifications which might be put forward have already been considered and rejected in earlier caselaw;
- it is incompatible with the Treaty itself, which continues to be the highest legal authority, quite independently of the Directive.

4. None of the arguments apparently put forward by the minister cast any doubt on this conclusion.

- The suggested reading of Article 7(1) shows no awareness of the legal context, and does not even fit the text;
- the proposal that as long as two different kinds of policy exist the law is not infringed makes no legal sense, and case law provides good reasons why it would be rejected.

5. Finally, perhaps most importantly, there appears to be an underlying perception that the Netherlands can design its healthcare in relative isolation from wider EU policy, and then defend it on narrow technical grounds, such as a lack of formal discrimination. This displays a lack of legal understanding of how EU law works. On the contrary, the fundamental, underlying, test which will be applied is whether the Netherlands policy contributes to the creation of a borderless single market, and to patient mobility, or whether it detracts from that policy. There can be little doubt that in significantly reducing the opportunities for treatment abroad for most Dutch patients the government has chosen a path incompatible with their legal obligations.

Consequences

6. If Article 13 were to be adopted, there would be an obligation on all Dutch courts and public authorities to treat it as non-applicable: to essentially ignore it, and to apply the substantive rights in the Treaty and Directive instead.[27] Formal adoption by the Dutch parliament would not be enough to give it binding force in the Netherlands. The view of the Court is that EU law takes precedence over national law, and that Member States have surrendered the power to legislate contrary to EU law. Where they appear to do so, that legislation must be set aside by all courts and authorities. A court in doubt, or uncomfortable about setting Article 13 aside, could of course refer the

[27] Case C-106/77 Simmenthal; Case C-118/00 Larsy.

question to the Court of Justice, but no judge, properly informed, could reasonably take the view that the revised Article 13 is enforceable law and leave the matter there.

7. In practice, a patient with a benefits-in-kind policy who received treatment abroad, sought reimbursement, and was refused it, would face two possibilities. They could sue the insurer directly for that reimbursement, and whether or not this succeeded would depend on the legal doctrine known as horizontal direct effect. It is open to argument whether this path would succeed, (although I think it likely that it would) and I am not asked to go into the question in more detail here.

   However, if it was not successful, because the Treaty and directive were not held to be enforceable directly against private insurers, then the patient would be able to claim compensation from the Dutch state for a breach of EU law, in failing to implement the Directive properly and/or to respect the Treaty. Given the clarity of the law, such a claim should be successful.

8. Furthermore, it seems very likely that in the event Article 13 were adopted by the Dutch parliament that the Commission would begin an enforcement action against the Netherlands, which could, ultimately, lead to a fine being imposed, if the Article were not removed from the law or amended quickly enough.

Hoogachtend

Gareth Davies